This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.AlaskaCare.gov or by calling 1-855-784-8646.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$300** person **/ $600** family (for premium and standard plans). **$500** person **/ $1,000** family (for economy plan). Doesn't apply to preventive care services from a **network provider** or **prescription drugs** purchased from a participating pharmacy.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 3 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 3 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. **$350** person (for premium), **$1,200** person (for standard) and **$2,000** person (for economy) after **deductible**. **$1,000** person/ **$2,000** family for prescription drugs.	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, balance-billed charges, expenses paid at a rate other than the normal **coinsurance**, expenses applied against **deductibles**, pre-certification penalties, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.

Is there an overall annual limit on what the plan pays?	Yes. Coverage for audio services is limited to **$3,000** person over thirty-six consecutive months.	This plan will pay for covered services only up to this limit during each coverage period, even if your own need is greater. You're responsible for all expenses above this limit. The chart starting on page 3 describes *specific* coverage limits, such as limits on the number of office visits.
Does this plan use a network of providers?	Yes. For a list of **network providers** go to **www.AlaskaCare.gov or call 1-855-784-8646.**	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 3 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No.	You can see the **specialist** you choose without permission from the plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 12. See your policy or plan document for additional information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If any **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use **in-network providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	10% (for premium), 20% (for standard), 30% (for economy) coinsurance.	Same as in-network provider.	————————none————————
	Specialist visit	10% (for premium), 20% (for standard), 30% (for economy) coinsurance.	Same as in-network provider.	————————none————————
	Other practitioner office visit	10% (for premium), 20% (for standard), 30% (for economy) coinsurance. ********** 20% coinsurance for audio benefits for all plans.	Same as in-network provider.	Coverage for chiropractic services is limited to 20 visits per benefit year.

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
	Preventive care/screening/immunization	No charge.	10% (for premium), 20% (for standard), 30% (for economy) coinsurance.	Preventive care, screening and immunizations not specifically identified as preventive services in the plan document are subject to 10% (for premium), 20% (for standard), 30% (for economy) coinsurance. Preventive services are limited to once per year.
If you have a test	Diagnostic test (x-ray, blood work)	10% (for premium), 20% (for standard), 30% (for economy) coinsurance.	Same as in-network provider.	————————none————————
	Imaging (CT/PET scans, MRIs)	10% (for premium), 20% (for standard), 30% (for economy) coinsurance.	Same as in-network provider.	Pre-certification is required for some imaging services when using of out-of-network providers. Failure to obtain pre-certification when required will result in a $400 penalty being assessed before benefits are paid. See your plan document for additional information about pre-certification. Call 1-855-784-8646 for pre-certification.

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.AlaskaCare.gov or by calling **1-855-784-8646.**	Generic & Brand Drugs	20% coinsurance (retail), subject to minimum and maximum limits. Retail minimum: $13 copay for up to 30-day supply; $21 copay for greater of 31-90-day or 100 unit supply. Retail maximum: $61 copay for up to 30-day supply; $122 copay for greater of 31-90-day or 100 unit supply. Mail order: $8 copayment (generic). $20 copayment (brand).	40% coinsurance (retail and mail order).	Covers up to a 30-day supply (retail prescription); greater of 31-90 day or 100 unit supply (retail and mail order prescription). **$1,000** person/**$2,000** person annual copay maximum applies to following prescriptions: up to a 30-day supply (retail prescription); greater of 31-90 day or 100 unit supply (retail and mail order prescriptions).

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
	Specialty drugs	20% coinsurance (retail), subject to minimum and maximum limits. Retail minimum: $13 copay for up to 30-day supply; $21 copay for greater of 31-90-day or 100 unit supply. Retail maximum: $61 copay for up to 30-day supply; $122 copay for 31-90-day or 100 unit supply. Mail order: $20 copayment.	40% coinsurance (retail and mail order).	Covers up to a 30-day supply (retail prescription); greater of 31-90 day or 100 supply (retail and mail order prescription). **$1,000** person / **$2,000** person annual copay maximum applies to following prescriptions: up to a 30-day supply (retail prescription); greater pf 31-90 day or 100 supply (retail and mail order prescriptions). Pre-certification is required for some specialty drugs when using of out-of-network providers. See your plan document for additional information about pre-certification. Call 1-855-784-8646 for pre-certification.

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% (for premium), 20% (for standard), 30% (for economy) coinsurance.	30% (for premium), 40% (for standard), 50% (for economy). Applies to hospital facilities only.	Pre-certification is required for use of out-of-network providers. Failure to obtain pre-certification will result in a $400 penalty being assessed before benefits are paid. Use of designated preferred hospital is required for non-emergency care in Anchorage and outside Alaska. Failure to use preferred hospital will result in a 20% reduction in benefits and the out-of-pocket limit will be doubled.
	Physician/surgeon fees	10% (for premium), 20% (for standard), 30% (for economy) coinsurance.	Same as in-network provider.	——————none——————
If you need immediate medical attention	Emergency room services	10% (for premium), 20% (for standard), 30% (for economy) coinsurance.	Same as in-network provider.	A $100 penalty will be assessed for non-emergency services received in an emergency room.
	Emergency medical transportation	10% (for premium), 20% (for standard), 30% (for economy) coinsurance.	Same as in-network provider.	——————none——————

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
	Urgent care	10% (for premium), 20% (for standard), 30% (for economy) coinsurance.	Same as in-network provider.	————————none————————
If you have a hospital stay	Facility fee (e.g., hospital room)	10% (for premium), 20% (for standard), 30% (for economy) coinsurance.	30% (for premium), 40% (for standard), 50% (for economy).	Pre-certification is required for use of out-of-network providers. Failure to obtain pre-certification will result in a $400 penalty being assessed before benefits are paid. Use of designated preferred hospital is required for non-emergency care in Anchorage and outside Alaska. Failure to use preferred hospital will result in a 20% reduction in benefits and the out-of-pocket limit will be doubled.
	Physician/surgeon fee	10% (for premium), 20% (for standard), 30% (for economy) coinsurance.	Same as in-network provider.	————————none————————

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	10% (for premium), 20% (for standard), 30% (for economy) coinsurance.	Same as in-network provider.	————————none————————
	Mental/Behavioral health inpatient services	10% (for premium), 20% (for standard), 30% (for economy) coinsurance.	30% (for premium), 40% (for standard), 50% (for economy).	Pre-certification is required for use of out-of-network providers. Failure to obtain pre-certification will result in a $400 penalty being assessed before benefits are paid. Use of an out-of-network provider will result in 20% reduction in benefits.
	Substance use disorder outpatient services	10% (for premium), 20% (for standard), 30% (for economy) coinsurance.	Same as in-network provider.	————————none————————
	Substance use disorder inpatient services	10% (for premium), 20% (for standard), 30% (for economy) coinsurance.	30% (for premium), 40% (for standard), 50% (for economy).	Pre-certification is required for use of out-of-network providers. Failure to obtain pre-certification will result in a $400 penalty being assessed before benefits are paid. Use of an out-of-network provider will result in 20% reduction in benefits.

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you are pregnant	Prenatal and postnatal care	10% (for premium), 20% (for standard), 30% (for economy) coinsurance.	Same as in-network provider.	————————none————————
	Delivery and all inpatient services	10% (for premium), 20% (for standard), 30% (for economy) coinsurance.	30% (for premium), 40% (for standard), 50% (for economy). Applies to hospital facilities only.	Pre-certification is required for use of out-of-network providers. Failure to obtain pre-certification will result in a $400 penalty being assessed before benefits are paid. Use of designated preferred hospital is required for non-emergency care in Anchorage and outside Alaska. Failure to use preferred hospital will result in a 20% reduction in benefits and the out-of-pocket limit will be doubled.

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	10% (for premium), 20% (for standard), 30% (for economy) coinsurance.	Same as in-network provider.	Pre-certification is required for use of out-of-network providers. Failure to obtain pre-certification will result in a $400 penalty being assessed before benefits are paid.
	Rehabilitation services	10% (for premium), 20% (for standard), 30% (for economy) coinsurance.	Same as in-network provider.	————————none————————
	Habilitation services	Not covered.	Not covered.	Not covered.
	Skilled nursing care	10% (for premium), 20% (for standard), 30% (for economy) coinsurance.	Same as in-network provider.	Pre-certification is required for use of out-of-network providers. Failure to obtain pre-certification will result in a $400 penalty being assessed before benefits are paid.
	Durable medical equipment	10% (for premium), 20% (for standard), 30% (for economy) coinsurance.	Same as in-network provider.	————————none————————
	Hospice service	10% (for premium), 20% (for standard), 30% (for economy) coinsurance.	Same as in-network provider.	Pre-certification is required for use of out-of-network providers. Failure to obtain pre-certification will result in a $400 penalty being assessed before benefits are paid.

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If your child needs dental or eye care	Eye exam	Not covered.	Not Covered.	Not covered.
	Glasses	Not covered.	Not Covered.	Not covered.
	Dental check-up	Not covered.	Not Covered.	Not Covered.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Dental care (Adult and Child) except as related to medical conditions of the teeth, jaw, and jaw joints as well as supporting tissues including bones, muscles, and nerves. Medical services include: inpatient hospital care, surgery, dental implants, services needed to treat accidental fractures, diagnosis/appliance therapy regarding the jaw joints and nonsurgical treatment of infections/diseases not related to the teeth, supporting bones or gums.
- Glasses
- Habilitation Services
- Infertility treatments
- Long-term care
- Routine eye care (Adult and Child)
- Routine foot care

Other Covered Services **(This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)**

- Acupuncture (only if performed by a physician as a form of surgical anesthesia)
- Bariatric surgery
- Chiropractic care (20 visit limit per benefit year).
- Cosmetic surgery (only for severe birth defects, disease, and to repair an injury resulting from an accident provided the treatment is started within 12 months of the accident).
- Non-emergency care when traveling outside the U.S. (excluding travel expenses)
- Private-duty nursing (provided by an R.N. or L.P.N. if medical condition requires skilled nursing services and visiting nursing care is inadequate)
- Weight loss programs

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-855-784-8646. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x 61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact the claims administrator at 1-855-784-8646 or the plan administrator at 1-800-821-2251 or:

Aetna
Attn: National Account CRT
PO Box 14079
Lexington, KY 40512-4079

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

Tagalog: Kung kailangan ninyo ang tulong sa Tagalog tumawag sa [1-855-784-8646].

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations (assuming family coverage under the **premium** option). Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the last page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $6,750
- **Patient pays** $790

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$300
Copays	$90
Coinsurance	$400
Limits or exclusions	$0
Total	**$790**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $4,000
- **Patient pays** $1,400

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$300
Copays	$700
Coinsurance	$200
Limits or exclusions	$200
Total	**$1,400**

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations (assuming family coverage under the **standard** option). Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the last page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $5,950
- **Patient pays** $1,590

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$300
Copays	$90
Coinsurance	$1200
Limits or exclusions	$0
Total	**$1590**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $3,800
- **Patient pays** $1,600

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$300
Copays	$700
Coinsurance	$400
Limits or exclusions	$200
Total	**$1,600**

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations (assuming family coverage under the **economy** option). Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the last page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $4,950
- **Patient pays** $2,590

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$500
Copays	$90
Coinsurance	$2000
Limits or exclusions	$0
Total	**$2,590**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $3,500
- **Patient pays** $1,900

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$500
Copays	$700
Coinsurance	$500
Limits or exclusions	$200
Total	**$1,900**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.